Supreme Court, U.S.
FILED

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NO.

IN THE
Supreme Court of the United States

October Term, _____

WILLIAM B. RICHARDSON
Petitioner

v.

UNITED STATES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL
Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR WRIT OF CERTIORARI

WILLIAM B. RICHARDSON, *pro se*
149 Westmoreland Avenue
Greensburg, PA 15601
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53 pp

THE QUESTIONS PRESENTED FOR REVIEW

Number One:

Are the remedies of title 42 USC § 1983 available to plaintiff (here-in-after "appellant") and applicable to both federal and state defendants?

Number Two:

Should the District Court have considered other jurisdictional possibilities besides 42 USC § 1983 and which were set out in the first paragraph of the amended complaint?

Number Three:

Should the Court of Appeals have considered jurisdiction under Title 28, United States Code, Section 1346 because the U.S. Attorney suggested such at page #2 of his Third Circuit Brief?

A LIST OF PARTIES TO THE PROCEEDING

Pro Se Plaintiff: William B. Richardson

Defendants: THE UNITED STATES And The Department Of Health And Human Services.

LOUIS SULLIVAN, The Secretary, Department of Health and Human Services.

THE KEYSTONE PEER REVIEW ORGANIZATION at its Harrisburg Office.

CARMINE J. STRIANO, KePRO, Director of Professional Relations.

PAT ELEY, RN, Area One Review Manager.

THE WESTMORELAND HOSPITAL ASSOCIATION in Greensburg, PA
a hospital).

GUY L. BELLANCA,
The Hospital's Medical Director, .

REBECCA MAZIARC, R.R.A., the Hospital's Director, Medical Records.

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REFERENCE TO THE OFFICIAL AND UNOFFICIAL REPORTS DELIVERED IN THE CASE BY OTHER COURTS OR ADMINISTRATIVE AGENCIES

Reference #1. The REPORT OF THE MAGISTRATE (see Appendix p. A-1) is the basis for dismissal. It was adopted by reviewing judges, beginning with the U.S. District Court (see pp. A-35 and A-36).

Reference #2. The Director, Division II, Office of Civil Actions, Office of Hearing and Appeals, Social Security Administration, Department of Health and Human Services (under the authority of the Secretary), filed a report dated October 24, 1990 (see Appendix, page A-7), which was on point herein to the effect that the Hospital's "billing practices were improper" and "The council will also ask the regional office to consider the beneficiary's request . . . regarding the 1989 deductible issue as a request for reconsideration on that matter."

Reference #3. A somewhat similar case addressing the relationship between the Peer Review Organization, the confidentiality of medical records, and federal and state law has been set out in: General Care Corp. v. Mid-South Foundation 778 F. Suppl. 405 (W.D. Tenn. 1991). See Argument, page 15.

GROUNDS FOR INVOKING SUPREME COURT JURISDICTION

(i) April 26, 1993: On this date, the Third Circuit Court of Appeals affirmed the REPORT and Judgment of the District Court. (See Appendix, page A-35.)

(ii) On September 14, 1993, a panel of the same Judges who affirmed in (i) above, denied a petition for rehearing. (See Appendix, page A-36.) On December 6, 1993, the Supreme Court granted a thirty day extension until January 12, 1994; and, on January 4, 1994, granted a thirty day extension until February 11, 1994.

(iii) Omitted.

(iv) Title 28 USC § 1254 is believed to confer jurisdiction on the Supreme Court to hear this matter.

THE CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES AND REGULATIONS INVOLVED

Constitutional Provisions: Amendments 1, 4, 5, 9, and 10. These constitutional amendments are referred to by number in the Amended Complaint (see page A-14 of Appendix). The relevant Amendments are set out in pertinent part under Argument.

State Statutes: MEDICAL RECORDS: Title 28 PA Code § 115.27: "All records shall be treated as confidential. Only authorized personnel shall have access to the records. The written authorization of the patient shall be presented and then maintained in the original record as authority for release of medical information outside the hospital."

Federal Statutes: Title 42 USC § 1983, Title 42 USC § 1320c and portions of Title 42 USC § 1320c-3 and 1320c-9.

§ 1983: "Every person who, under color of any statute, ordinance, regulation, custom, or usage, or any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

§ 1320c: "The purpose of this part is to establish . . . the functions such peer review organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part."

§ 1320c-3: "Functions of peer review organizations

"(a) Review of professional activities; determination of payment; determination of review authority; consultation with professional health care practitioners; standards of health care; other duties.

"Any utilization and quality control peer review organization entering into contract with the Secretary under this part must perform the following functions:

"(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d) of this sections, of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under subchapter XVIII of this chapter (including where payment is made for such services to eligible organizations pursuant to contracts under section 1395mm of this title) for the purpose of determining whether—

"(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1395y of this title;

"(B) the quality of such services meets professionally recognized standards of health care; and

"(C) in case such services and items are proposed to be provided in a hospital or other health care facility on

an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type . . . ."[balance of Title 42 USC § 1320c-3 not copied].

A CONCISE STATEMENT OF THE CASE

The contract between KePRO and the U.S. called for KePRO to do one thing they were not authorized to do under State law (see § 1320c-3(a)(1)(C)). This allowed them to investigate — but only where hospitalization was "proposed"— for the purpose of determining if the "proposed" hospitalization might be accomplished in a lesser facility or on an outpatient basis. This was the only performance on their part that might bring the Medicare patient face to face with KePRO.

In appellant's case, appellant called KePRO in to investigate if his in-patient hospitalization should be continued or whether he had to transfer to a nursing home. Dr. Kenny (of KePRO) determined that appellant should remain in the hospital under Medicare and at Medicare expense.

Following Dr. Kenny's investigation, KePRO, without appellant's knowledge or authorization, continued to obtain appellant's photostatted Medical Records. Eventually, they obtained the Hospital's entire file.

Appellant was released to his home on June 14, 1989. Under date of July 24, 1989, appellant received a bill from the hospital for $3,413.50. It states, "This is the balance due after Medicare Termination." KePRO later scheduled and held a secret hearing before a panel of three Doctors (unidentified), and the verdict was that appellant owed the $3,413.50 plus a $560.00 yearly deductible. This hearing was not authorized by law, and it was fraudulent.

CONCLUSION

While not having fully recovered from his original injury and his hospital ordeal; and, even though KePRO tried to nullify its hearing, the Westmoreland Hospital has never acknowledged that appellant did not owe them anything — in fact, they should reimburse appellant for the deductible.

Furthermore, it developed that through all of appellant's litigation, KePRO had filed in Court the appellant's photostatted Medical Records, and they have gone through the full run of litigation and had absolutely nothing to do with the issues involved. These Records were used to discourage the appellant from exercising his Amendment I right to petition.

There records are now in the District Court in Pittsburgh, PA filed by the Department of Health and Human Services through its Office of Hearings and Appeals, and available to the public.

BASIS FOR JURISDICTION IN COURT OF FIRST INSTANCE

The Complaint lists in paragraph #1, five jurisdictional statutes (see page A -14 of Appendix,. Appellant has argued only one of these in connection with the remedies afforded by Title 42 USC § 1983 because the dismissal opinion (REPORT) of the District Court dealt only on § 1983. The jurisdictional statute involved is Title 28 USC § 1343 (see Para #1 of Complaint).

The U.S. Attorney believes there was jurisdiction under Title 28 USC § 1346.

ARGUMENT

The Writ of Certiorari should issue based on the remedies allowed in Title 42 USC § 1983 and the case returned to the District Court for trial under the Civil Rights Jurisdictional Statute, title 28 USC § 1343.

This is not an argument that there is incompatibility between federal and state laws on the confidentiality of Medical Records. It is, however, an argument that where the federal government uses a state organization, Congress can pass laws that enlarge upon state law as to the protection of the property rights of the Medicare citizen. This is true even though, the Secretary, Health and Human Services may adopt inconsistent regulations.

See General Care Corp. v. Mid-South Foundation, 778 Fed. Supp. 405 (1988).

Where the U.S. and its Department of Health and Human Services attempt to verify the necessity of hospitalization beforehand and requires direct contact between the Medicare patient and the PRO (Peer Review Organization) doing the verification, it is absolutely necessary that the federal government and its Department HHS take long initial steps and contacts with PRO personnel to see that they do not mistreat the Medicare patient, and this was never done in this case. It should be done even though the PRO personnel are responsible for knowing the law.

In addition, the PRO and the Hospital should be frequently and heavily told not to try to use false claims, false hearings, and Medical Records to combat a disenchanted patient.

The Amendment One Connection

The petitioner should be permitted "to petition the government for a redress of grievances" without fear that all of his adversaries have access to his Medical Records for one entire 32 day hospitalization and given to them free gratis so that he will be discouraged from Court appearances.

The Amendment Four Connection

The petitioner is at that stage where hospitalization is a fact of life. Such persons should be secure in "their persons, houses, and papers and effects, against unreasonable searches and seizures . . . ."

The Amendment Five Connection

The petitioner should not be deprived of ". . . property, without due process of law."

GENERAL SUPREME COURT HOLDINGS

Right to petition. Freedom of religion, speech, press, assembly, and petition are preferred rights of the Federal Constitution.

"In order to establish personal liability on the part of a government official in a federal civil rights action under 42 USCS § 1983, it is enough to show that the official, acting under color of state law, caused the deprivation of a federal right; in contrast, a governmental entity is liable in an official-capacity suit under § 1983 only when the entity is a moving force behind the deprivation, thus requiring the entity's policy or custom to have played a part in the violation of federal law." See head note #3 Kentucky v Graham, 473 US 159, 87 L Ed 2d 114, 117 (1985).

"Section 1983 provides a federal remedy for 'the deprivation of any rights, privileges, or immunities secured by the Constitution and laws.' As the language of the statute plainly indicates, the remedy encompasses violations of federal statutory as well as constitutional rights. We have repeatedly held that the coverage of the statute must be broadly construed." Golden State Transit v Los Angeles, 493 US 103, 105; 107 L Ed 2d 420, 427 (1989).

"In order to act 'under color of state law' within the meaning of 42 USCS § 1983, the defendant in a § 1983 action must have exercised power possessed by virtue of state law and made possible only because the defendant is clothed with the authority of state law." See head note #5 West v Atkins, 487 US 42; 101 L Ed 2d 40, 43 (1988).

"The United States Supreme Court holds allegations of a pro se complaint to less stringent standards than formal pleadings drafted by lawyers. . . . A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." See head note #1, #2, Haines v Kerner, 404 US 519, 520; 30 L Ed 2d 652, 653 (1971).

"A broad construction of § 1983 is compelled by the statutory languae, which speaks of deprivations of '*any* rights, privileges, or immunities secured by the Constitution and laws.'" (Emphasis added.) Accordingly, we have 'repeatedly held that the coverage of [§ 1983]

must be broadly construed." Dennis v Higgins, 498 US 439, 443; 112 L Ed 2d 969, 975 (1991).

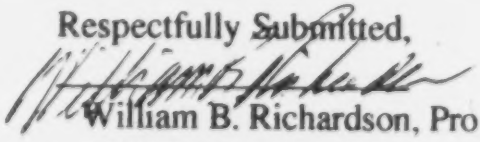
"Any disclosure by Medicare Peer Review Organization of detailed information relating to its investigation of health care rendered to patient by hospital would violate Tennessee statute governing confidentiality of medical review materials." Head note #5. Discussed pages 416 to 418 in General Care Corporation v. Mid-South Foundation, 778 F. Supp. 405, 416, 417 (1988).

CONCLUSION

The facts alleged in the Amended Complaint (pages A-14 through A-29) clearly accord the appellant other remedies to be adjudicated.

All of the defendants filed Rule 12(b)(6) motions for dismissal, "For purposes of review of Rule 12(b)(6) dismissal, the factual allegations of Burch's complaint are taken as true." Zinermon v. Burch, 494 US 113, 118; 108 L Ed 2d 100, 109 (1990). Accordingly, when one reads the Amended Complaint one is reading proven facts for all practical purposes in resolving the issues herein.

Respectfully Submitted,



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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
PENNSYLVANIA**

WILLIAM B. RICHARDSON,
Plaintiff,

v. Civil Action No. 91-0005

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH
AND HUMAN SERVICES, ET AL.,
Defendants

REPORT

GARY L. LANCASTER,
United States Magistrate

This is a civil rights action filed pursuant to 28 USC § 1983. Plaintiff is proceeding pro se. He has already filed an original complaint and a first amended complaint. However, because plaintiff's complaints consisted merely of vague and conclusory statements, we ordered plaintiff to file a third amended complaint setting forth his allegations with greater clarity. We also provided plaintiff with our standard "Directions for Filing Amended Complaint in Pro Se Litigation." Currently before the Court is plain

tiff's second amended complaint. For the reasons set forth below, this complaint should be dismissed.[1]

I. BACKGROUND

Due to the lack of clarity in plaintiff's pleadings, we are frankly unable to provide an extensive amount of background with respect to plaintiff's claim. However, we glean that plaintiff alleges some type of due process violation in connection with a bill for medical services he received form the Westmoreland County Hospital. Apparently, plaintiff is objecting to paying the bill because he was displeased with the quality of the services rendered. He also appears to be displeased with the manner in which his objection was dealt with by the appropriate authorities.

II. DISCUSSION

Generally, federal pleading practice requires only a short plain statement of the claim showing that the pleader is entitled to relief. Fed.R.Civ.P. 8(a)(2), 28 U.S.C.A. However, the Court of Appeals for the Third Circuit has modified the customary liberal notice pleading in the context of civil rights cases. The Court reasoned:

---

[1] Defendants have all filed various motions to dismiss for failure tos tate a claim for which relief can be granted.

The Dual policy concerns of protecting state officials from a deluge of frivolous claims and providing state officials with sufficient notice of the claims asserted to enable preparation of responsive pleadings have led us to impose on section 1983 claims the additional pleading requirement that the 'complaint contain a modicum of factual specificity, identifying the particular conduct of defendants that is alleged to have harmed the plaintiffs.'

Colburn v. Upper Darby 838 F.2d 663, 666 (3d Cir. 1988) (quoting Ross v. Meagan 638 F.2d 646, 650 (3d Cir. 1981)); see also Frazier v. Southeastern Pennsylvania Transportation Authority, 785 F. 2d 65, 67 (3d Cir. 1986); Rotolo v. Borough of Charleroi, 532 F. 2d 920, 922 (3d Cir. 1976). There is no simple formula for determining the sufficient level of factual specificity. Each complaint must be determined on a case-by-case basis, Frazier, 785 F.2d at 68; but generally, "the crucial questions are whether sufficient facts are pleaded to determine that the complaint is not frivolous, and to provide defendants with adequate notice to frame an answer." ID. Accord District Council 47, America Federation of State, County and Municipal Employees v. Bradley, 795 F.2d 310, 313 (3d Cir. 1986). The failure to plead with sufficient specificity will subject the complaint to dismissal either because the lack of specificity renders the complaint frivolous, as that term is used in 28 U.S.C. § 1915 (d), see Green v. White, 616 F.2d 1054 (8th Cir. 1980), Carollo-Gardner v. Diners

Club, 628 F. Supp. 1253, 1256 n. 5 (E.D. N.Y. 1986); or because a vague and conclusory complaint fails to state a claim for which relief can be granted. Darr v. Wolfe, 767 F.2d 79, 81 (3d Cir. 1985).

The allegations in plaintiff's amended complaint are still vague and not sufficiently clear to advise the court as to what each defendant has done and how plaintiff has been harmed. While the court is required to allow liberal amendment of civil rights complaints to remedy such defects, see Rotolo, 532 F.2d at 923, we have already afforded plaintiff an opportunity to do so. The increasingly large volume of pro se civil rights cases places a great burden on the courts and necessitates certain court-imposed limitations on our resources. See generally Gagliardi v. McWilliams, 834 F.2d 81, 83 (3d Cir. 1987). Consequently, plaintiff is not entitled to successive amendments in the hope that he will eventually perfect the pleading. Because plaintiff has failed to amend the complaint as ordered, the entire complaint is dismissible on that basis alone pursuant to Fed.R.Civ.P. Rule 41 (b). Torino v. Texaco, Inc., 378 F.2d 268 (3d Cir. 1967). Clearly, this is such a case.

In accordance with the Magistrate's Act, 28 U.S.C. § 636 (b) (1) (B) and (C), and Rule 4 of the Local Rules for Magistrates, the parties are allowed ten days from the date of service to file objections to this report.

Gary L Lancaster
United States Magistrate

Dated: November 18, 1991

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

WILLIAM B. RICHARDSON,
Plaintiff,

v. Civil Action No. 91-0005

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH
AND HUMAN SERVICES, ET AL.,
Defendants

MEMORANDUM ORDER

This action was referred to the United States Magistrate Judge Gary L. Lancaster in accordance with the Magistrates Act, 28 U.S.C. § 636 (b) (1), and Rules 3 and 4 of the Local Rules of Magistrates. On November 19, 1991, the Magistrate Judge filed his Report, which

concluded that plaintiff's complaint, as amended, should be dismissed. Plaintiff filed timely objections to the Report.

After de novo review of the pleading and documents in the case, together with the Magistrate Judge's Report and objections thereto, the following ORDER is entered this 16th day of December, 1991:

The complaint is dismissed.

The Report filed by Magistrate Judge Lancaster is adopted as the Opinion of the Court.

s/Alan N. Bloch, J.

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

WILLIAM B. RICHARDSON,
Plaintiff,

v.

Civil Action No. 91-5
Judge Alan N. Bloch
Magistrate Judge Lancaster

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH
AND HUMAN SERVICES, ET AL.,
Defendants

ORDER

AND NOW, this 19th day of February, 1992, upon consideration of Plaintiff's Pro Se rule 60 (b) Motion for Relief from Judgment of Dismissal filed in the above captioned matter on February 14, 1992,

IT IS HEREBY ORDERED that said Motion is DENIED.

A.N. Bloch
United States District Judge

Department of
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARING AND APPEALS

ORDER OF APPEALS COUNCIL

In the case of	Claim for
William B. Richardson	Hospital Insurance Benefits
(Claimant)	
	415-46-5567
	(Social Security Number)

This case is before the Appeals Council pursuant to Health Care Financing and Social Security Administration

regulations (42 CFR 473.46 and 20 CFR 404.967) to review the order of dismissal dated April 24, 1990. By a notice dated August 24, 1990, the Appeals Council informed the beneficiary that it was granting the request for review. The beneficiary has responded by letter dated September 18, 1990.

The Appeals Council has considered the record before the Administrative Law Judge. Additionally, the Council has considered the brief submitted by the beneficiary with his request for review and his letters to the Council dated July 12 and September 18, 1990. In deciding to review the Administrative Law Judge's dismissal, the Council has applied the provision of 20 CFR 404.970 that a case be reviewed if there is an error of law. In this case, the regulatory citations made in the original dismissals order were incorrect.

The hospitalization in question began on May 13, 1989. The provider advised the beneficiary on June 5, 1989 that it considered his care beginning June 5, 1989 to be noncovered under Medicare because it could be safely rendered in another setting; the beneficiary was further advised that he would be liable for all charges if he remained in the hospital after June 8, 1989. The beneficiary appealed this action, and by notice dated June 7, 1989, the peer review organization (PRO) overturned the hospital-initiated denial and ruled that the beneficiary's continued

stay after June 5 was medically necessary and appropriate. The PRO notice stated that the beneficiary would not incur any financial liability as a result of the provider letter issued June 5, except for the deductible, coinsurance, or any convenience services not normally covered by Medicare. The beneficiary remained in the hospital until June 14, 1989.

Acting on a request by the provider, the PRO reconsidered and reversed its initial determination and held on August 15, 1989 that the beneficiary did not need acute hospital care after June 5, 1989 but could appropriately have been treated in a skilled nursing facility. The PRO advised the beneficiary that he was responsible for payment of the hospital charges for June 8 to June 14, 1989. The beneficiary objected to the reconsideration reversal by letter dated August 15, 1990, and upon further study the PRO realized that it should not have accepted the provider request for reconsideration, because a provider has no right to reconsideration where the PRO initial determination was, as here, an allowance on the coverage questions of medical necessity, reasonableness and appropriateness of setting. Under 42 CFR 473.16, a provider has a right to reconsideration only of an initial denial of a coverage issue. To correct its oversight, the PRO reopened reconsideration, dismissed the request for reconsideration, and reinstated the coverage allowance of June 7, 1989.

The reinstated initial PRO allowance was fully favorable on all coverage questions (42 CFR 473.14 (a) and for all days. 42 CFR 473.44 (a) and 405.740 (a) direct that the amount in controversy be computed as the actual amount charged the individual for the items and services in question less deductible and coinsurance amounts if applicable, but in this case the hospital charges for the beneficiary's continued care June 8 to June 14, 1989 were voided by the PRO coverage allowance (42 CFR 412.42 (c) (3) (v)). Under specific rules of 42 CFR 405.740, there is no amount in controversy with regard to the hospital services claim for June 8 to June 14, 1989, and the Council therefore finds that dismissal of the request for hearing filed October 12, 1989 is required pursuant to 42 CFR 473.44 (c).

In his letter dated September 18, 1990, the beneficiary asserts that the PRO's reopening action was not legitimate. However, under the regulations — in particular 42 CFR 473.48 — a PRO may reopen and revise its reconsidered determination, either on its own motion or at the request of a party, within one year from the date of the reconsidered determination. The PRO reopening action in this case met the time constraints and otherwise complied with section 473.48, and the Council finds that it supplanted the prior reconsidered determination as provided by section 473.38 (b). The retracted reconsidered determination is of no effect, the initial

determination is reinstated, and, as discussed above, there is no amount in controversy since the initial determination is favorable to the beneficiary. As to the beneficiary's contention that the regulations are inconsistent with the law, such issue may not be considered in this forum. The regulations represent the Secretary's interpretation of the statute, they have been duly promulgated, and accordingly they are binding on the Administrative Law Judges and Appeals Council.

The beneficiary raised two new claims on his hearing request. He asserted that the intermediary erroneously held him responsible for two inpatient deductibles in 1989. While question involving the deductible quality for administrative review (42 CFR 405.704 (b) (2), the beneficiary nevertheless does not have a right to a hearing on this issue unless the initial determination has been reconsidered (42 CFR 405.720 (a)), and there is no evidence that that review step has been completed. With regard to the beneficiary's contention that his employer group health insurance was improperly terminated, this actin does not fit any listed in (42 CFR 405.704 (a) or (b) and thus does not qualify for administrative review generally or for Administrative Law Judge consideration in particular.

The Appeals Council concludes that the request for hearing filed on October 12, 1989 should have been

dismissed by the Administrative Law Judge on three separate bases. Regarding the claim for hospital services furnished June 8 to June 14, 1989, the dismissal basis is less than $200 in controversy and the regulatory authority is CFR 473.40 (a) and 473.44 (c). On the claim regarding inpatient deductibles in 1989, the dismissal basis is no reconsideration rendered and the regulatory authority is 42 CFR 405.720 (a) and 20 CFR 404.957 (c) (2). On the claim for continued group health coverage, the dismissal basis is no right to administrative review at any level and the regulatory authority is 42 CFR 405.704 and 405.720 and 20 CFR 404.957 (c) (2).

Accordingly, the Appeals Council modifies the order issued by the Administrative Law Judge on April 24, 1990 and dismisses the request for hearing filed on October 12, 1989 pursuant to the above-stated provisions. The PRO determination dated June 7, 1989 stands as the final determination of the Secretary on the beneficiary's claim for hospital services furnished June 8 to June 14, 1989.

The Appeal Council will forward the claim file to the Health Care Financing Administration regional office for consideration of the beneficiary's contention that the provider's billing practices have been improper and that it has charged him for service days June 8 to June 14, 1989. Any charge action by the provider subsequent to the

reinstatement of the PRO initial determination would appear to contravene 42 CFR 412.42 (c) (3) (v). The council will also ask the regional office to consider the beneficiary's request for hearing of October 12, 1989 regarding the 1989 deductible issue as a request for reconsideration on that matter.

Notice of this action is hereby given by mailing a copy to the beneficiary.

APPEALS COUNCIL
Constance T. O'Bryant, Member
William C. Taylor, Member

Date: October 24, 1990

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

WILLIAM B. RICHARDSON,
Plaintiff,

v. Civil Action No. 91-5

United States of America, et al.

AMENDED COMPLAINT

1. Jurisdiction is based on the following Federal statutes:
   Title 28 USC 1331 - Federal Question.
   Title 28 USC 1343 - Civil Rights Denial & Conspiracy.
   Title 28 USC 1346 - United States as Defendant.
   Title 28 USC 1361 - Mandamus for US Officer do duty.
   Title 28 USC 2201 - Declaratory Judgment.
   Title 28 USC 2202 - Further Declaratory Relief.

2. PARTIES: (a.) The plaintiff is a 72 year old male, who worked until recently. As a result of an accident, he was hospitalized on two occasions in 1989. Until then, he had never before needed hospitalization. Part of his injury from the accident was to his left leg. An operation was performed for a broken tibia and fibula and a metal plate and screws were installed. Later, around this hardware, the bone and bone marrow became infected with a hemolitic (Group G) streptococcus. A lengthy hospitalization then followed.

(b.) The defendants, THE UNITED STATES OF AMERICA, the DEPARTMENT OF HEALTH AND HUMAN SERVICES, and its Secretary, LOUIS SULLIVAN, administer the Medicare Trust Fund. The Secretary contracts with Peer Review Organizations to perform the functions outlined in title 42 USC § 1320c-3. One of these functions (1320c-3 (a) (13) is to " . . . perform . . . review . . . with respect to early re-admission

cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards - - -." In addition, he must see that the contracts convey "definitions" and "functions" and "confidentiality of Medical Records" and "related administrative matters (see title 42 USC § 1320c - PURPOSES). It is significant that this first statute on Peer Review Organizations which states in broad terms the contractual "PURPOSES" to be imposed contains only four broad categories of Congressional concern and one of these is: "Confidentiality of Medical Records."

(c.) The defendant KEYSTONE PEER REVIEW ORGANIZATION (KePRO) is a solely owned subsidiary of the Pennsylvania Medical Society. This Society recently filed a lawsuit to prevent a Pennsylvania law from taking effect which limited Doctors to payments approved by Medicare even though the Doctor agrees to the Medicare approval in advance of treatment. The Society is also in other business for Doctors — this includes malpractice insurance.

(d.) The KePRO defendants, Director STRIANO and manager ELEY, are officials with authority to prescribe certain overall policies for conduct of the utilization and quality control aspects. Director STRIANO prescribes state-wide policy while Manager ELEY manages and makes independent judgment concerning reviews and convening of reconsideration hearings for Area I.

(e.) The WESTMORELAND HOSPITAL ASSOCIATION is the only hospital within the City of Greensburg. The hospital contracts with Medicare. It is registered as "non-profit" but the State Health Care Cost Containment Council in December 1990 report (latest) shows a profit (excess of revenue over expenses) of $2,875,724.00 for the year ending June 30th, 1989. The City of Greensburg and the Greensburg Parking Authority each filed an Answer to a Complaint filed against them in Common Pleas Court by the Westmoreland Hospital Association in which the Hospital represented itself as a "Non-Profit Corporation" (see No. 6621 of 1990). The City and the Parking Authority in their Answers denied that the Hospital was a non-profit organization and denied that all members of the public had access to health care provided by the Hospital.

(f.) GUY L. BELLANCA and REBECCA MAZIARC are directors at the Hospital. Dr. Bellanca is the Medical Director and Ms. Maziarc is the Director, Medical Records. Both have the usual responsibilities associated with their offices. However, the modern Medical Director now has to contend with Utilization Review and Peer Review Organizations. This makes every Medicare patient suspect because of the potential gain or loss depending on length of stay. Ms. Maziarc maintains the confidentiality of the Medical Records. She is the last resort for determining release of records except for Medical treatment purposes in the hospital by hospital

associated Doctors. It is illegal to send photostatic copies of Medical Records to outsiders without authorization; without a signed receipt and other formalities; and perhaps even an answer to some questions, like: Why photostats? Authority of what person? Or law?

3. The hospitalization periods were from (first period) January 19, 1989 to February 2, 1989 and (second period) May 13, 1989 to June 14: on the first hospitalization, the left tibia and fibula were broken and a plate and ten screws were applied with an eleventh screw through the fracture itself. The causes of the second hospitalization have never been investigated by the Keystone Peer Review Organization although requested by the patient-beneficiary herein. Instead, they collect photostats of the patient-beneficiary's Medical Records for study at their offices so they can introduce them into evidence in case the Hospital has a bill it wants KePRO to collect.

4. Plaintiff has a property interest in his Medical Records. "Property interests are not created by the (U.S.) Constitution . . . they are created . . . by existing rules or understanding . . . such as state law." (Bd. of Regents v Roth, 408 US 564, 577). No Federal law can endow a State created entity with power to confiscate a State citizen's property.

5. On June 5, 1989, plaintiff received a notice from the hospital stating that after PRO Review and beginning June 8, he might have to pay the hospital bill. The name of Rose Marie Pritts, M.D. was subscribed but it was

obviously not her signature. The so-called "COURT TRANSCRIPT INDEX," or the "Administrative Records" as they were called by the U.S. Attorney, implies that the Medical Records (5-13-89 to 6-5-89) were attached to the Pritt's letter (p. 96) — but this is false. Anyone can see that the Medical Records (p. 106 to 290) begin after the letter "To Whom It May Concern" (p. 105) signed by Rebecca J. Maziarc and dated May 26, 1989.

6. By June 7, 1989, Kevin J. Kenny, M.D., Area I Medical Director (KePRO) had determined that hospitalization was "medically necessary and appropriate."

7. Plaintiff received a bill from the hospital dated July 24, 1989, which stated on its face: "THIS IS THE BALANCE DUE AFTER MEDICARE TERMINATION." Under date of July 31, 1989, KePRO notified plaintiff that a Reconsideration Hearing was scheduled August 10 — obviously related to the Hospital's bill.

8. The taking of the Medical Records, the billing by the hospital, and the Reconsideration hearing on August 10 were illegal. On the date that the notice of hearing was sent out, KePRO received the last of plaintiff's Medical Records (p. 106).

9. Plaintiff appeared at the Reconsideration hearing and was to meet his lawyer there. Plaintiff never saw his lawyer until after the hearing. Plaintiff and his wife arrived first and were taken to a back room. It was purposefully arranged that plaintiff would go through the hearing

without the benefit of his attorney — and this is what happened.

10. The Reconsideration determination was issued under date of August 15, 1989, and was signed by Pat Eley, RN the Monroeville Manager. It advised the plaintiff that he owed $3,413.50 plus $560.00 deductible. The deductible was paid on plaintiff's first hospitalization (Jan. 19 to Feb. 2) but was collected a second time by the Hospital and the money never returned.

11. On September 13, 1989, plaintiff received a telephone call from Carmine J. Striano, Director of Professional Relations for KePRO. He favored the procedure adopted by Pat Eley and was opposing KePRO's move to cancel the Eley letter. He maintained KePRO was changing its position only because it was ordered to do so but that his reading of CFR's gave KePRO the authority to hold the Reconsideration hearing now being canceled and such practice would continue. Reading him the law had no effect. (See Exhibit #1 — attached).

12. Under date of September 14, 1989, Melanie Waters, RN, Mgr., Utilization Review, in a letter marked "CONFIDENTIAL" advised plaintiff that the determination made by KePRO's Reconsideration panel on August 10, 1989, and reported in a letter dated August 15 and signed by Pat Eley was not within KePRO's authority (letter described para 10).

13. Plaintiff filed three complaints in Mid-October (pgs 51-69) with Secretary's Office of Hearings and Appeals because he believed there was conspiracy, prejudice, illegality, and violations of plaintiff's rights. (See Exhibit #2.) There was a duty on the Administrative law Judge to get his complaints to the right section. Only one was considered by the ALJ. See the "Administrative Record" pages 1 to 69. O.H.A.'s only concern was to make it a "benefits' claim and deny jurisdiction on the grounds it lacked the necessary "amount in controversy." O.H.A. does not honor the Amendment I right to petition the Government for a redress of grievances.

14. There is no statutory authorization (either Federal or State) for the prejudicial handling of the plaintiff's Medical Records by the Hospital, KePRO, or the Secretary HHS through his attorney. This unauthorized and purposeful attempt to illegally possess photostatic copies of plaintiff's Medical Records has resulted in a gross violation of plaintiff's right to privacy. It is deliberate and premeditated and no doubt is used to try and dampen plaintiff's desire to proceed in Court. This does not lessen in any way the other charges plaintiff has made, but shows a tie-in that is sponsored by the association of groups with similar interests working together to get everything they can from Medicare and S.S. Trust Funds and its beneficiaries.

DECLARATORY JUDGMENT

15. The plaintiff moves this honorable Court to issue a Declaratory Judgment having the force and effect of law that:

a. the unauthorized, prejudicial and unnecessary transfer of plaintiff's Medical records from the Hospital to KePRO, from KePRO to the Secretary's O.H.A. and then made public by filing with the U.S. District Court is an interference with a property interest plaintiff has in his Medical Records that amounts to confiscation.

b. the plaintiff cannot be deprived of his interest in the confidentiality of his Medical Records by two state entities contracting with the Federal government; nor even by the Federal government itself. This right is protected by the Federal constitution. Amendments 1,2-4,5-9.10; often referred to as the "right of privacy."

c. the disclosure of Medical records alone without authority is highly offensive to a reasonable person. An intentional intrusion upon the solitude or seclusion of another reflecting his private concerns and affairs is actionable whether such private concerns and affairs are given publicity or not. (INTRUSION UPON SECLUSION).

d. the Medical Records disclosed by the defendants had notations in them which were uncomplimentary and disparaging. Certain statements in the Medical Records would be highly offensive to a reasonable per

son, and is not of legitimate concern to the public. (PUBLICITY GIVEN TO PRIVATE LIFE).

e. certain pages of these Medical Records place plaintiff in a false light. This is done by recording false statements and by personal interpretations that have not been checked out by the person writing for the Record. These false statements are now presented to the public by filing in the District Court and elsewhere; possibly, including places unknown since plaintiff's records were addressed "to whom it may concern." Such display of false statements are highly offensive to the reasonable person and have injured plaintiff. (PUBLICITY PLACING PERSON IN FALSE LIGHT).

f. that the defendant Hospital collected the deductible twice.

g. that KePRO is not a bill collector for hospitals.

h. that the hospital as a public entity enjoying non-profit tax status and receiving benefits from the Federal Government, the S.S. Trust fund, the Medicare-Medicaid Trust Fund, and the City of Greensburg is obligated to answer plaintiff's inquiries about his Medical bills — even if the bills are approved by Medicare.

i. that it is not in the best interest of the beneficiaries of the Trust fund to be subjected to a State created entity that is going to abuse its authority in administering a sensitive matter such as the care, health, and privacy of the elderly Medicare patient.

j. that plaintiff has been denied:

(i) his Amendment I constitutional right to freedom of speech and to petition his government for a redress of grievances.

(ii) his Amendment 4 constitutional right to be secure against unreasonable searches and seizures.

(iii) his Amendment 5 constitutional right to due process.

(iv) his Amendment 9 constitutional right to confidentiality of his Medical Records as a right retained by the People.

(v) his Amendment 10 constitutional right to enjoy a property right in his Medical Records that puts the power and the obligation to protect such property in the hands of the State. Any law of the Federal Government that purports to authorize an artificially created state entity to confiscate such property is not made pursuant to the Constitution of the United States and is unconstitutional and void (Article VI).

k. that plaintiff's letter to Carmine J. Striano, Director, Professional Relations, dated September 13, 1989, be logged as part of the "Administrative Record" in this case but never filed therein and marked "Exhibit #1" to this complaint.

l. that plaintiff's letter to Administrative Law Judge Gerald Stitz, Office of Hearings and Appeals, Johnstown, PA, dated April 10, 1990, be logged as part of the "Administrative Record" in this case not previously filed therein and marked "Exhibit #2" to this Complaint.

m. that the Administrative Records contain the plaintiff's Medical Records which were illegally confiscated by the defendants and incorporated in the so-called "Administrative Records" and they cannot be a part of any District Court proceeding.

n. that the matter should be the subject of a criminal investigation on the part of the U.S. Attorney instead of filing plaintiff's property as part of Federal case: especially, without authority.

o. that the Medical Records made part of the so-called Administrative Records are not "evidence." There is no "Court Transcript" as the Index tries to imply. These Medical Records have never been part of any legitimate proceedings.

MANDAMUS TO UNITED STATES DEFENDANTS

16. Mandamus should issue to compel the United States defendants:

*** to acknowledge the validity of the plaintiff's "Motions to Abrogate Public Access to Medical Records" filed by plaintiff with the Court and Clerk on April 23, 1991 and to order the United States defendants herein to comply with said Motion promptly and without further delay. (Motion attached to Complaint as Exhibit #3).

MANDAMUS TO SECRETARY, HEALTH AND HUMAN SERVICES

17. Mandamus should issue to compel the Secretary, H.H.S.:

*** to evaluate ". . . the quality and effectiveness of" the Keystone Peer Review Organization in carrying out the functions: "of the contract" between the two as authorized by title 42 USC 1320c-2 (c) (2). This evaluation should concentrate on KePRO's "quality and effectiveness" in performing the functions required by title 42 USC § 1320c3 (a) (14) which specifies that KePRO ". . . must perform the following functions: . . . conduct an appropriate review of all written complaints about the quality of services not meeting professionally recognized standards . . . the organization shall inform the individual . . . of the organization's final disposition of the complaint."

CONSPIRACY

18. The defendants have, purposefully and intentionally, and acting under color of law, conspired to deprive the plaintiff — or have failed to prevent deprivation by the plaintiff — of rights, privileges, and immunities, accorded him by the United States Constitution and laws made in pursuance thereof. Each of the defendants alone knew — or should have known — that the plaintiff's

rights to be covered by Medicare accrued unquestionably upon the issuance of the "Review" determination by Dr. Kenny and from that time on he was not to be disturbed. Plaintiff should have been free to recover from a serious infection which became embedded in the fracture cite by entry through the skin due to negligence. Instead, he was confronted with the harassment of a Reconsideration Hearing arranged between the Hospital and the Peer Review Organization. This prejudicial miscarriage of authority carried over into the Office of Hearings and Appeals who flagrantly granted lack of jurisdiction to hear when the Constitution says it must be heard (see exhibit #2). Not satisfied with the injustice the defendants had already heaped on the plaintiff, the Secretary, H.H.S., made plaintiff's Medical Records available to the public by filing them in the U.S. District Court. These records had been illegally obtained and falsely represented as part of the records of a Reconsideration hearing which, by law, cannot possibly exist. All of which, has left plaintiff mentally and physically impaired to his detriment — and will not go away.

ACTION FOR DEPRIVATION OF RIGHTS

19. The Westmoreland Hospital, purposefully and intentionally, and acting under color of law, caused the plaintiff to be subjected to a demand for payment of $3,413.50 which was covered by Medicare. Although

knowing the bill was not the obligation of the plaintiff, the Hospital proceeded to bill the plaintiff and, to date, has not withdrawn its billing or apologized for the false billing.

20. The Westmoreland Hospital, purposefully and intentionally, and acting under color of law, accepted nearly seven thousand dollars from the plaintiff (through his auto carrier) for the first hospitalization. The foregoing payments included the Medicare deductible which the hospital collected from plaintiff's supplemental carrier. Attempts to get the Hospital to return the over-payment have resulted in no response.

21. The Keystone Peer Review Organization, purposefully and intentionally, and acting under color of law:

a. falsified a Reconsideration Hearing in order to embarrass the plaintiff and to collect a bill for the Westmoreland Hospital which the plaintiff did not owe.

b. persuaded the Westmoreland Hospital to supply KePRO with the complete Medical Records of plaintiff's hospitalization for the period May 13, 1989 to June 14, 1989 by photostatting same and making delivery outside the Hospital when it was illegal for KePRO to have such photostats. (Plaintiff has no way of knowing if other Records of plaintiff's are in their possession.)

MISHANDLING OF PLAINTIFF'S ATTEMPTS TO RESOLVE ISSUES WITHIN SECRETARY'S ADMINISTRATIVE SETUP

22. The Secretary's Office of Hearings and Appeals and his Appeals Section mishandled the petitions for appeal (see pgs 50 to 67, Adm. Records):

a. by not hearing a petition based on the Amendment One right to petition for a redress of grievance or by assisting the plaintiff into the correct channels if, in fact, he was in the wrong appeals arena (see Exhibit #3 which was not included in the Secretary's Administrative Record) and by refusing to indicate any concern regarding plaintiff's allegations.

b. by holding the "amount in controversy" insufficient.

c. by not treating the plaintiff's Medical Records in a confidential manner and by not giving the same consideration to plaintiff's Social Security Records. (see p.68 — Adm. Records).

FURTHER PRAYER FOR RELIEF

23. This honorable Court adjudge, decree and declare the rights and other legal relations of the parties to the matter here in controversy in order that such declarations shall have the force and effect of law.

24. That a jury be impaneled to try the cause for compensatory and exemplary damages.

25. That by reason of the premises here-to-fore set out in this complaint and the humiliation and degradation fostering emotional and mental distress, the damages herein will exceed $50,000.00.

Respectfully submitted,
William B. Richardson

End of Amended Complaint

NOTE

Appellant's note to filing of the Amended Complaint:

There were three attachments (exhibits) to the Amended Complaint which are not being printed herein because they add nothing to the validity of the Argument for Jurisdiction.

Exhibit #1. Letter to Carmine J. Striano (now defendant herein)

Exhibit #2. Letter to Administrative Law Judge Gerald Stitz, Johnstown, PA.

The above two exhibits were filed with the Complaint because they were submitted with the records filed by the Office of Hearings and Appeals.

End of Amended Complaint

Exhibit #3. This was a Motion to Abrogate Public Access to Medical Records. This motion had been previously filed with the District Court on April 23, 1991.

STATE STATUTES INCLUDED IN APPENDIX

63 P.S Section 425.2.

As used in this act:

"Peer review" means the procedure for evaluation by professional health care providers of the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, claims review, and the compliance of a hospital, nursing home or convalescent home or other health care facility operated by a professional health care provider with the standards set by an association of health care providers and with applicable laws, rules and regulations.

"Professional health care provider" means individuals or organizations who are approved, licensed or otherwise regulated to practice or operate in the health care field under the laws of the Commonwealth, including, but not limited to, the following individuals or organizations: . . .

PROFESSIONS AND OCCUPATIONS

63 P.S. § 425.3 Immunity from liability

(a) Notwithstanding any other provision of law, no person providing information to any review organizations shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, unless:

(1) such information is unrelated to the performance of the duties and functions of such review organization, or

(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

(b)(1) No individual who, as a member or employee of any review organization or who furnishes professional counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of review, organizations, to have violated any criminal law, or to be civilly liable under any law, provided he has exercised due care.

(2) The provision s of paragraph (1) of this subsection shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action. . . .

63 P.S. § 425.4 Confidentiality of review organization's records

The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof: Provided, however, That information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters, within his knowledge, but the said witness cannot be asked about his testimony before such a committee or opinions formed by him as a result of said committee hearings. . . .

TITLE 42 USC § 1320C-9. (PERTINENT PARTS)

Prohibition against disclosure of information

(a) Freedom of Information Act inapplicable; exceptions to nondisclosure

An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of Title 5 (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except—

(1) to the extend that may be necessary to carry out the purposes of this part,

(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

(3) in accordance with subsection (b) of this section. . .

The penalty provided in subsection (c) of this section shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving

such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

(c) Penalties

It shall be unlawful for any person to disclose any such information described in subsection (a) of this section other than for the purposes provided in subsections (a) and (b) of this section, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

(d) Subpoena and discovery proceedings regarding patient records

No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpoena or discovery proceedings in a civil action.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 92-3089

WILLIAM B. RICHARDSON,

Appellant

v.

UNITED STATES OF AMERICA, ET AL.

Appeal from the United States District Court
for the Western District of Pennsylvania
(D.C. Civ. No. 91-00005)
District Judge: Honorable Alan N. Bloch

Submitted April 12, 1993 Before:
MANSMANN, COWEN AND ALITO, Circuit Judges.

JUDGMENT ORDER

After consideration of all contentions raised by the appellant, it is ADJUDGED AND ORDERED that the judgment of the district court be and is hereby affirmed.

Costs taxed against the appellant.

BY THE COURT,
Carol Los Mansmann,
Circuit Judge

Attest:
P. Douglas Sisk, Clerk
April 26, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 92-3089

WILLIAM B. RICHARDSON,
Appellant

v.

UNITED STATES OF AMERICA, ET AL.

SUR PETITION FOR REHEARING

Present: MANSMANN, COWEN AND ALITO, Circuit Judges.

The petition for panel rehearing filed by appellant in the above entitled case having been submitted to the judges who participated in the decision of this court, and no judge who concurred in the decision having asked for rehearing, the petition for panel rehearing is denied.

BY THE COURT,

Carol Los Mansmann
Circuit Judge

September 14, 1993